

AMENDED IN ASSEMBLY APRIL 8, 2002

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL

No. 2178

Introduced by Assembly Member Goldberg

February 20, 2002

An act to amend Section 1357 of, ~~and to add Section 1357.18 to,~~ the Health and Safety Code, and to amend Section 10700 of, ~~and to add Section 10718.6 to,~~ the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2178, as amended, Goldberg. Health care.

Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and of disability insurers by the Insurance Commissioner. Existing law regulates plans and insurers that provide coverage to small employers and defines the term “small employer” for those purposes. A willful violation of the provisions governing health care service plans is a crime.

This bill would provide that the definition of the term “small employer” for this type of coverage includes an employer that is subject to a local living wage law *or other legislation enacted by a local government that regulates the minimum hourly compensation of employees*. ~~The bill would additionally specify that those employers are not required to obtain that coverage for their employees who are not subject to a local living wage law.~~

Because a violation of the bill’s requirements on health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1357 of the Health and Safety Code is
2 amended to read:

3 1357. As used in this article:

4 (a) “Dependent” means the spouse or child of an eligible
5 employee, subject to applicable terms of the health care plan
6 contract covering the employee, and includes dependents of
7 guaranteed association members if the association elects to include
8 dependents under its health coverage at the same time it determines
9 its membership composition pursuant to subdivision (o).

10 (b) “Eligible employee” means ~~either~~ any of the following:

11 (1) Any permanent employee who is actively engaged on a
12 full-time basis in the conduct of the business of the small employer
13 with a normal workweek of at least 30 hours, at the small
14 employer’s regular places of business, who has met any statutorily
15 authorized applicable waiting period requirements. The term
16 includes sole proprietors or partners of a partnership, if they are
17 actively engaged on a full-time basis in the small employer’s
18 business and included as employees under a health care plan
19 contract of a small employer, but does not include employees who
20 work on a part-time, temporary, or substitute basis. It includes any
21 eligible employee as defined in this paragraph who obtains
22 coverage through a guaranteed association. Employees of
23 employers purchasing through a guaranteed association shall be
24 deemed to be eligible employees if they would otherwise meet the
25 definition except for the number of persons employed by the
26 employer. Permanent employees who work at least 20 hours but
27 not more than 29 hours are deemed to be eligible employees if all
28 four of the following apply:



1 (A) They otherwise meet the definition of an eligible employee
2 except for the number of hours worked.

3 (B) The employer offers the employees health coverage under
4 a health benefit plan.

5 (C) All similarly situated individuals are offered coverage
6 under the health benefit plan.

7 (D) The employee must have worked at least 20 hours per
8 normal workweek for at least 50 percent of the weeks in the
9 previous calendar quarter. The health care service plan may
10 request any necessary information to document the hours and time
11 period in question, including, but not limited to, payroll records
12 and employee wage and tax filings.

13 (2) Any member of a guaranteed association as defined in
14 subdivision (o).

15 (3) *Any employee of a small employer as defined in paragraph*
16 *(3) of subdivision (l) whether employed by that employer on a*
17 *part-time or full-time basis.*

18 (c) “In force business” means an existing health benefit plan
19 contract issued by the plan to a small employer.

20 (d) “Late enrollee” means an eligible employee or dependent
21 who has declined enrollment in a health benefit plan offered by a
22 small employer at the time of the initial enrollment period
23 provided under the terms of the health benefit plan and who
24 subsequently requests enrollment in a health benefit plan of that
25 small employer, provided that the initial enrollment period shall be
26 a period of at least 30 days. It also means any member of an
27 association that is a guaranteed association as well as any other
28 person eligible to purchase through the guaranteed association
29 when that person has failed to purchase coverage during the initial
30 enrollment period provided under the terms of the guaranteed
31 association’s plan contract and who subsequently requests
32 enrollment in the plan, provided that the initial enrollment period
33 shall be a period of at least 30 days. However, an eligible
34 employee, any other person eligible for coverage through a
35 guaranteed association pursuant to subdivision (o), or dependent
36 shall not be considered a late enrollee if any of the following is
37 applicable:

38 (1) The individual meets all of the following requirements:

1 (A) He or she was covered under another employer health
2 benefit plan or no share-of-cost Medi-Cal coverage at the time the
3 individual was eligible to enroll.

4 (B) He or she certified at the time of the initial enrollment that
5 coverage under another employer health benefit plan or no
6 share-of-cost Medi-Cal coverage was the reason for declining
7 enrollment, provided that, if the individual was covered under
8 another employer health plan, the individual was given the
9 opportunity to make the certification required by this subdivision
10 and was notified that failure to do so could result in later treatment
11 as a late enrollee.

12 (C) He or she has lost or will lose coverage under another
13 employer health benefit plan as a result of termination of
14 employment of the individual or of a person through whom the
15 individual was covered as a dependent, change in employment
16 status of the individual or of a person through whom the individual
17 was covered as a dependent, termination of the other plan's
18 coverage, cessation of an employer's contribution toward an
19 employee or dependent's coverage, death of the person through
20 whom the individual was covered as a dependent, legal separation,
21 divorce, or loss of no share-of-cost Medi-Cal coverage.

22 (D) He or she requests enrollment within 30 days after
23 termination of coverage or employer contribution toward
24 coverage provided under another employer health benefit plan.

25 (2) The employer offers multiple health benefit plans and the
26 employee elects a different plan during an open enrollment period.

27 (3) A court has ordered that coverage be provided for a spouse
28 or minor child under a covered employee's health benefit plan.

29 (4) (A) In the case of an eligible employee as defined in
30 paragraph (1) of subdivision (b), the plan cannot produce a written
31 statement from the employer stating that the individual or the
32 person through whom the individual was eligible to be covered as
33 a dependent, prior to declining coverage, was provided with, and
34 signed, acknowledgment of an explicit written notice in boldface
35 type specifying that failure to elect coverage during the initial
36 enrollment period permits the plan to impose, at the time of the
37 individual's later decision to elect coverage, an exclusion from
38 coverage for a period of 12 months as well as a six-month
39 preexisting condition exclusion, unless the individual meets the
40 criteria specified in paragraph (1), (2), or (3).



(B) In the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or paragraph (2) or (3).

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change.

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of "COBRA" set forth in subdivision (e) of Section 1373.621 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of coverage.

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf, and on behalf of his or her dependent within 30 days following the date

1 of marriage, birth, adoption, or placement for adoption, in which
2 case the effective date of coverage shall be the first day of the
3 month following the date the completed request for enrollment is
4 received in the case of marriage, or the date of birth, or the date of
5 adoption or placement for adoption, whichever applies. Notice of
6 the special enrollment rights contained in this paragraph shall be
7 provided by the employer to an employee at or before the time the
8 employee is offered an opportunity to enroll in plan coverage.

9 (8) The individual is an eligible employee who has declined
10 coverage for himself or herself or his or her dependents during a
11 previous enrollment period because his or her dependents were
12 covered by another employer health benefit plan at the time of the
13 previous enrollment period. That individual may enroll himself or
14 herself or his or her dependents for plan coverage during a special
15 open enrollment opportunity if his or her dependents have lost or
16 will lose coverage under that other employer health benefit plan.
17 The special open enrollment opportunity shall be requested by the
18 employee not more than 30 days after the date that the other health
19 coverage is exhausted or terminated. Upon enrollment, coverage
20 shall be effective not later than the first day of the first calendar
21 month beginning after the date the request for enrollment is
22 received. Notice of the special enrollment rights contained in this
23 paragraph shall be provided by the employer to an employee at or
24 before the time the employee is offered an opportunity to enroll in
25 plan coverage.

26 (e) “New business” means a health care service plan contract
27 issued to a small employer that is not the plan’s in force business.

28 (f) “Preexisting condition provision” means a contract
29 provision that excludes coverage for charges or expenses incurred
30 during a specified period following the employee’s effective date
31 of coverage, as to a condition for which medical advice, diagnosis,
32 care, or treatment was recommended or received during a
33 specified period immediately preceding the effective date of
34 coverage.

35 (g) “Creditable coverage” means:

36 (1) Any individual or group policy, contract, or program that is
37 written or administered by a disability insurer, health care service
38 plan, fraternal benefits society, self-insured employer plan, or any
39 other entity, in this state or elsewhere, and that arranges or provides
40 medical, hospital, and surgical coverage not designed to

1 supplement other private or governmental plans. The term
2 includes continuation or conversion coverage but does not include
3 accident only, credit, coverage for onsite medical clinics,
4 disability income, Medicare supplement, long-term care, dental,
5 vision, coverage issued as a supplement to liability insurance,
6 insurance arising out of a workers' compensation or similar law,
7 automobile medical payment insurance, or insurance under which
8 benefits are payable with or without regard to fault and that is
9 statutorily required to be contained in any liability insurance
10 policy or equivalent self-insurance.

11 (2) The federal Medicare program pursuant to Title XVIII of
12 the Social Security Act.

13 (3) The medicaid program pursuant to Title XIX of the Social
14 Security Act.

15 (4) Any other publicly sponsored program, provided in this
16 state or elsewhere, of medical, hospital, and surgical care.

17 (5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071)
18 (Civilian Health and Medical Program of the Uniformed Services
19 (CHAMPUS)).

20 (6) A medical care program of the Indian Health Service or of
21 a tribal organization.

22 (7) A state health benefits risk pool.

23 (8) A health plan offered under 5 U.S.C.A. Chapter 89
24 (commencing with Section 8901) (Federal Employees Health
25 Benefits Program (FEHBP)).

26 (9) A public health plan as defined in federal regulations
27 authorized by Section 2701(c)(1)(I) of the Public Health Service
28 Act, as amended by Public Law 104-191, the Health Insurance
29 Portability and Accountability Act of 1996.

30 (10) A health benefit plan under Section 5(e) of the Peace
31 Corps Act (22 U.S.C.A. Sec. 2504(e)).

32 (11) Any other creditable coverage as defined by subdivision
33 (c) of Section 2701 of Title XXVII of the federal Public Health
34 Services Act (42 U.S.C. Sec. 300gg(c)).

35 (h) "Rating period" means the period for which premium rates
36 established by a plan are in effect and shall be no less than six
37 months.

38 (i) "Risk adjusted employee risk rate" means the rate
39 determined for an eligible employee of a small employer in a
40 particular risk category after applying the risk adjustment factor.

(j) “Risk adjustment factor” means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(k) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30–39

40–49

50–54

55–59

60–64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(3) (A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state’s population. Geographic regions established pursuant to this section shall, as a group, cover the

entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) (i) In determining rates for small employers, a plan that does not operate statewide shall use no more than the number of geographic regions in the state that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No plan shall have less than one geographic area.

(ii) If the formula in clause (i) results in a plan that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the plan may have two geographic regions, provided that no county is divided into more than one region.

Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(I) "Small employer" means any of the following:

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include

1 employers with at least three eligible employees until July 1, 1997,
2 and two eligible employees thereafter. In determining the number
3 of eligible employees, companies that are affiliated companies and
4 that are eligible to file a combined tax return for purposes of state
5 taxation shall be considered one employer. Subsequent to the
6 issuance of a health care service plan contract to a small employer
7 pursuant to this article, and for the purpose of determining
8 eligibility, the size of a small employer shall be determined
9 annually. Except as otherwise specifically provided in this article,
10 provisions of this article that apply to a small employer shall
11 continue to apply until the plan contract anniversary following the
12 date the employer no longer meets the requirements of this
13 definition. It includes any small employer as defined in this
14 paragraph who purchases coverage through a guaranteed
15 association, and any employer purchasing coverage for employees
16 through a guaranteed association.

17 (2) Any guaranteed association, as defined in subdivision (n),
18 that purchases health coverage for members of the association.

19 (3) Any employer subject to a local living wage law *or other*
20 *legislation enacted by a local government that regulates the*
21 *minimum hourly compensation of employees, whether-mandatory*
22 *or voluntary, and whether the employee is employed part time, full*
23 *time, or on a temporary basis- mandatory or voluntary.*

24 (m) “Standard employee risk rate” means the rate applicable
25 to an eligible employee in a particular risk category in a small
26 employer group.

27 (n) “Guaranteed association” means a nonprofit organization
28 comprised of a group of individuals or employers who associate
29 based solely on participation in a specified profession or industry,
30 accepting for membership any individual or employer meeting its
31 membership criteria, and that (1) includes one or more small
32 employers as defined in paragraph (1) of subdivision (l), (2) does
33 not condition membership directly or indirectly on the health or
34 claims history of any person, (3) uses membership dues solely for
35 and in consideration of the membership and membership benefits,
36 except that the amount of the dues shall not depend on whether the
37 member applies for or purchases insurance offered to the
38 association, (4) is organized and maintained in good faith for
39 purposes unrelated to insurance, (5) has been in active existence
40 on January 1, 1992, and for at least five years prior to that date, (6)

1 has included health insurance as a membership benefit for at least
 2 five years prior to January 1, 1992, (7) has a constitution and
 3 bylaws, or other analogous governing documents that provide for
 4 election of the governing board of the association by its members,
 5 (8) offers any plan contract that is purchased to all individual
 6 members and employer members in this state, (9) includes any
 7 member choosing to enroll in the plan contracts offered to the
 8 association provided that the member has agreed to make the
 9 required premium payments, and (10) covers at least 1,000
 10 persons with the health care service plan with which it contracts.
 11 The requirement of 1,000 persons may be met if component
 12 chapters of a statewide association contracting separately with the
 13 same carrier cover at least 1,000 persons in the aggregate.

14 This subdivision applies regardless of whether a contract issued
 15 by a plan is with an association or a trust formed for, or sponsored
 16 by, an association to administer benefits for association members.

17 For purposes of this subdivision, an association formed by a
 18 merger of two or more associations after January 1, 1992, and
 19 otherwise meeting the criteria of this subdivision shall be deemed
 20 to have been in active existence on January 1, 1992, if its
 21 predecessor organizations had been in active existence on January
 22 1, 1992, and for at least five years prior to that date and otherwise
 23 met the criteria of this subdivision.

24 (o) "Members of a guaranteed association" means any
 25 individual or employer meeting the association's membership
 26 criteria if that person is a member of the association and chooses
 27 to purchase health coverage through the association. At the
 28 association's discretion, it also may include employees of
 29 association members, association staff, retired members, retired
 30 employees of members, and surviving spouses and dependents of
 31 deceased members. However, if an association chooses to include
 32 these persons as members of the guaranteed association, the
 33 association shall make that election in advance of purchasing a
 34 plan contract. Health care service plans may require an association
 35 to adhere to the membership composition it selects for up to 12
 36 months.

37 (p) "Affiliation period" means a period that, under the terms
 38 of the health care service plan contract, must expire before health
 39 care services under the contract become effective.

~~SEC. 2. Section 1357.18 is added to the Health and Safety Code, to read:~~

~~1357.18. A small employer described in paragraph (3) of subdivision (l) of Section 1357 who obtains coverage under a health care service plan contract pursuant to this article for employees who are subject to a local living wage law, is not required to obtain coverage under this article for his or her other employees who are not subject to a local living wage law.~~

~~SEC. 3.~~

SEC. 2. Section 10700 of the Insurance Code is amended to read:

10700. As used in this chapter:

(a) “Agent or broker” means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) “Benefit plan design” means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) “Board” means the Major Risk Medical Insurance Board.

(d) “Carrier” means any disability insurance company or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder. For the purposes of Articles 3 (commencing with Section 10719) and 4 (commencing with Section 10730), “carrier” also includes health care service plans.

(e) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (z).

(f) “Eligible employee” means ~~either~~ *any* of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, in the small employer’s regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer’s business, and they are included as employees under a health benefit plan of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee as defined in this paragraph who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. A permanent employee who works at least 20 hours but not more than 29 hours is deemed to be an eligible employee if all four of the following apply:

(A) The employee otherwise meets the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employee health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The insurer may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (z).

(3) Any employee of ~~an~~ *a small* employer as defined in paragraph (3) of subdivision (w) *whether employed by that employer on a part-time or full-time basis*.

(g) “Enrollee” means an eligible employee or dependent who receives health coverage through the program from a participating carrier.

(h) “Financially impaired” means, for the purposes of this chapter, a carrier that, on or after the effective date of this chapter, is not insolvent and is either:

(1) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations.

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(i) “Fund” means the California Small Group Reinsurance Fund.

(j) “Health benefit plan” means a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered eligible employees of a small employer and their dependents. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(k) “In force business” means an existing health benefit plan issued by the carrier to a small employer.

(l) “Late enrollee” means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association’s health benefit plan and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, another person eligible for coverage through a guaranteed association pursuant to subdivision (z), or dependent

1 shall not be considered a late enrollee if any of the following is
2 applicable:

3 (1) The individual meets all of the following requirements:

4 (A) He or she was covered under another employer health
5 benefit plan or no share-of-cost Medi-Cal coverage at the time the
6 individual was eligible to enroll.

7 (B) He or she certified at the time of the initial enrollment that
8 coverage under another employer health benefit plan or no
9 share-of-cost Medi-Cal coverage was the reason for declining
10 enrollment provided that, if the individual was covered under
11 another employer health plan, the individual was given the
12 opportunity to make the certification required by this subdivision
13 and was notified that failure to do so could result in later treatment
14 as a late enrollee.

15 (C) He or she has lost or will lose coverage under another
16 employer health benefit plan as a result of termination of
17 employment of the individual or of a person through whom the
18 individual was covered as a dependent, change in employment
19 status of the individual, or of a person through whom the
20 individual was covered as a dependent, the termination of the other
21 plan's coverage, cessation of an employer's contribution toward
22 an employee or dependent's coverage, death of the person through
23 whom the individual was covered as a dependent, legal separation,
24 divorce, or loss of no share-of-cost Medi-Cal coverage.

25 (D) He or she requests enrollment within 30 days after
26 termination of coverage or employer contribution toward
27 coverage provided under another employer health benefit plan.

28 (2) The individual is employed by an employer who offers
29 multiple health benefit plans and the individual elects a different
30 plan during an open enrollment period.

31 (3) A court has ordered that coverage be provided for a spouse
32 or minor child under a covered employee's health benefit plan.

33 (4) (A) In the case of an eligible employee as defined in
34 paragraph (1) of subdivision (f), the carrier cannot produce a
35 written statement from the employer stating that the individual or
36 the person through whom an individual was eligible to be covered
37 as a dependent, prior to declining coverage, was provided with,
38 and signed acknowledgment of, an explicit written notice in
39 boldface type specifying that failure to elect coverage during the
40 initial enrollment period permits the carrier to impose, at the time

1 of the individual's later decision to elect coverage, an exclusion
2 from coverage for a period of 12 months as well as a six-month
3 preexisting condition exclusion unless the individual meets the
4 criteria specified in paragraph (1), (2), or (3).

5 (B) In the case of an eligible employee who is a guaranteed
6 association member, the plan cannot produce a written statement
7 from the guaranteed association stating that the association sent a
8 written notice in boldface type to all potentially eligible
9 association members at their last known address prior to the initial
10 enrollment period informing members that failure to elect
11 coverage during the initial enrollment period permits the plan to
12 impose, at the time of the member's later decision to elect
13 coverage, an exclusion from coverage for a period of 12 months
14 as well as a six-month preexisting condition exclusion unless the
15 member can demonstrate that he or she meets the requirements of
16 subparagraphs (A), (C), and (D) of paragraph (1) or paragraph (2)
17 or (3).

18 (C) In the case of an employer or person who is not a member
19 of an association, was eligible to purchase coverage through a
20 guaranteed association, and did not do so, and would not be
21 eligible to purchase guaranteed coverage unless purchased
22 through a guaranteed association, the employer or person can
23 demonstrate that he or she meets the requirements of
24 subparagraphs (A), (C), and (D) of paragraph (1), or paragraph (2)
25 or (3), or that he or she recently had a change in status that would
26 make him or her eligible and that application for coverage was
27 made within 30 days of the change.

28 (5) The individual is an employee or dependent who meets the
29 criteria described in paragraph (1) and was under a COBRA
30 continuation provision and the coverage under that provision has
31 been exhausted. For purposes of this section, the definition of
32 "COBRA" set forth in subdivision (e) of Section 1373.62 shall
33 apply.

34 (6) The individual is a dependent of an enrolled eligible
35 employee who has lost or will lose his or her no share-of-cost
36 Medi-Cal coverage and requests enrollment within 30 days after
37 notification of this loss of coverage.

38 (7) The individual is an eligible employee who previously
39 declined coverage under an employer health benefit plan and who
40 has subsequently acquired a dependent who would be eligible for

1 coverage as a dependent of the employee through marriage, birth,
2 adoption, or placement for adoption, and who enrolls for coverage
3 under that employer health benefit plan on his or her behalf, and
4 on behalf of his or her dependent within 30 days following the date
5 of marriage, birth, adoption, or placement for adoption, in which
6 case the effective date of coverage shall be the first day of the
7 month following the date the completed request for enrollment is
8 received in the case of marriage, or the date of birth, or the date of
9 adoption or placement for adoption, whichever applies. Notice of
10 the special enrollment rights contained in this paragraph shall be
11 provided by the employer to an employee at or before the time the
12 employee is offered an opportunity to enroll in plan coverage.

13 (8) The individual is an eligible employee who has declined
14 coverage for himself or herself or his or her dependents during a
15 previous enrollment period because his or her dependents were
16 covered by another employer health benefit plan at the time of the
17 previous enrollment period. That individual may enroll himself or
18 herself or his or her dependents for plan coverage during a special
19 open enrollment opportunity if his or her dependents have lost or
20 will lose coverage under that other employer health benefit plan.
21 The special open enrollment opportunity shall be requested by the
22 employee not more than 30 days after the date that the other health
23 coverage is exhausted or terminated. Upon enrollment, coverage
24 shall be effective not later than the first day of the first calendar
25 month beginning after the date the request for enrollment is
26 received. Notice of the special enrollment rights contained in this
27 paragraph shall be provided by the employer to an employee at or
28 before the time the employee is offered an opportunity to enroll in
29 plan coverage.

30 (m) “New business” means a health benefit plan issued to a
31 small employer that is not the carrier’s in force business.

32 (n) “Participating carrier” means a carrier that has entered into
33 a contract with the program to provide health benefits coverage
34 under this part.

35 (o) “Plan of operation” means the plan of operation of the
36 fund, including articles, bylaws and operating rules adopted by the
37 fund pursuant to Article 3 (commencing with Section 10719).

38 (p) “Program” means the Health Insurance Plan of California.

39 (q) “Preexisting condition provision” means a policy
40 provision that excludes coverage for charges or expenses incurred

1 during a specified period following the insured's effective date of
2 coverage, as to a condition for which medical advice, diagnosis,
3 care, or treatment was recommended or received during a
4 specified period immediately preceding the effective date of
5 coverage.

6 (r) "Creditable coverage" means:

7 (1) Any individual or group policy, contract, or program, that
8 is written or administered by a disability insurer, health care
9 service plan, fraternal benefits society, self-insured employer plan,
10 or any other entity, in this state or elsewhere, and that arranges or
11 provides medical, hospital, and surgical coverage not designed to
12 supplement other private or governmental plans. The term
13 includes continuation or conversion coverage but does not include
14 accident only, credit, coverage for onsite medical clinics,
15 disability income, Medicare supplement, long-term care, dental,
16 vision, coverage issued as a supplement to liability insurance,
17 insurance arising out of a workers' compensation or similar law,
18 automobile medical payment insurance, or insurance under which
19 benefits are payable with or without regard to fault and that is
20 statutorily required to be contained in any liability insurance
21 policy or equivalent self-insurance.

22 (2) The federal Medicare program pursuant to Title XVIII of
23 the Social Security Act.

24 (3) The medicaid program pursuant to Title XIX of the Social
25 Security Act.

26 (4) Any other publicly sponsored program, provided in this
27 state or elsewhere, of medical, hospital, and surgical care.

28 (5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071)
29 (Civilian Health and Medical Program of the Uniformed Services
30 (CHAMPUS)).

31 (6) A medical care program of the Indian Health Service or of
32 a tribal organization.

33 (7) A state health benefits risk pool.

34 (8) A health plan offered under 5 U.S.C.A. Chapter 89
35 (commencing with Section 8901) (Federal Employees Health
36 Benefits Program (FEHBP)).

37 (9) A public health plan as defined in federal regulations
38 authorized by Section 2701(c)(1)(I) of the Public Health Service
39 Act, as amended by Public Law 104-191, the Health Insurance
40 Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(s) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than six months.

(t) "Risk adjusted employee risk rate" means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(u) "Risk adjustment factor" means the percent adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard claims. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(v) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30–39

40–49

50–54

55–59

60–64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the health benefit plan will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer carriers shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple.

1 (C) One adult and child or children.

2 (D) Married couple and child or children.

3 (3) (A) In determining rates for small employers, a carrier that
4 operates statewide shall use no more than nine geographic regions
5 in the state, have no region smaller than an area in which the first
6 three digits of all its ZIP Codes are in common within a county and
7 shall divide no county into more than two regions. Carriers shall
8 be deemed to be operating statewide if their coverage area includes
9 90 percent or more of the state's population. Geographic regions
10 established pursuant to this section shall, as a group, cover the
11 entire state, and the area encompassed in a geographic region shall
12 be separate and distinct from areas encompassed in other
13 geographic regions. Geographic regions may be noncontiguous.

14 (B) In determining rates for small employers, a carrier that does
15 not operate statewide shall use no more than the number of
16 geographic regions in the state than is determined by the following
17 formula: the population, as determined in the last federal census,
18 of all counties which are included in their entirety in a carrier's
19 service area divided by the total population of the state, as
20 determined in the last federal census, multiplied by nine. The
21 resulting number shall be rounded to the nearest whole integer. No
22 region may be smaller than an area in which the first three digits
23 of all its ZIP Codes are in common within a county and no county
24 may be divided into more than two regions. The area encompassed
25 in a geographic region shall be separate and distinct from areas
26 encompassed in other geographic regions. Geographic regions
27 may be noncontiguous. No carrier shall have less than one
28 geographic area.

29 (w) "Small employer" means any of the following:

30 (1) Any person, proprietary or nonprofit firm, corporation,
31 partnership, public agency, or association that is actively engaged
32 in business or service that, on at least 50 percent of its working days
33 during the preceding calendar quarter, or preceding calendar year,
34 employed at least two, but not more than 50, eligible employees,
35 the majority of whom were employed within this state, that was not
36 formed primarily for purposes of buying health insurance and in
37 which a bona fide employer-employee relationship exists. In
38 determining whether to apply the calendar quarter or calendar year
39 test, the insurer shall use the test that ensures eligibility if only one
40 test would establish eligibility. However, for purposes of

subdivisions (b) and (h) of Section 10705, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply until the health benefit plan anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (y), that purchases health coverage for members of the association.

(3) Any employer subject to a local living wage law *or other legislation enacted by a local government that regulates the minimum hourly compensation of employees*, whether ~~mandatory or voluntary~~, and ~~whether the employee is employed part time, full time, or on a temporary basis~~. For purposes of this *mandatory or voluntary*. For purposes of this chapter, the definition of small employer provided in this paragraph shall apply when the terms “employer” or “qualified employer” are used.

(x) “Standard employee risk rate” means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(y) “Guaranteed association” means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers as defined in paragraph (1) of subdivision (w), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the

1 member applies for or purchases insurance offered by the
2 association, (4) is organized and maintained in good faith for
3 purposes unrelated to insurance, (5) has been in active existence
4 on January 1, 1992, and for at least five years prior to that date, (6)
5 has been offering health insurance to its members for at least five
6 years prior to January 1, 1992, (7) has a constitution and bylaws,
7 or other analogous governing documents that provide for election
8 of the governing board of the association by its members, (8) offers
9 any benefit plan design that is purchased to all individual members
10 and employer members in this state, (9) includes any member
11 choosing to enroll in the benefit plan design offered to the
12 association provided that the member has agreed to make the
13 required premium payments, and (10) covers at least 1,000
14 persons with the carrier with which it contracts. The requirement
15 of 1,000 persons may be met if component chapters of a statewide
16 association contracting separately with the same carrier cover at
17 least 1,000 persons in the aggregate.

18 This subdivision applies regardless of whether a master policy
19 by an admitted insurer is delivered directly to the association or a
20 trust formed for or sponsored by an association to administer
21 benefits for association members.

22 For purposes of this subdivision, an association formed by a
23 merger of two or more associations after January 1, 1992, and
24 otherwise meeting the criteria of this subdivision shall be deemed
25 to have been in active existence on January 1, 1992, if its
26 predecessor organizations had been in active existence on January
27 1, 1992, and for at least five years prior to that date and otherwise
28 met the criteria of this subdivision.

29 (z) "Members of a guaranteed association" means any
30 individual or employer meeting the association's membership
31 criteria if that person is a member of the association and chooses
32 to purchase health coverage through the association. At the
33 association's discretion, it may also include employees of
34 association members, association staff, retired members, retired
35 employees of members, and surviving spouses and dependents of
36 deceased members. However, if an association chooses to include
37 those persons as members of the guaranteed association, the
38 association must so elect in advance of purchasing coverage from
39 a plan. Health plans may require an association to adhere to the
40 membership composition it selects for up to 12 months.



(aa) “Affiliation period” means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

~~SEC. 4. Section 10718.6 is added to the Insurance Code, to read:~~

~~10718.6. A small employer described in paragraph (3) of subdivision (w) of Section 10700 who obtains coverage under a health benefit plan pursuant to this chapter for employees who are subject to a local living wage law, is not required to obtain coverage under this chapter for his or her other employees who are not subject to a local living wage law.~~

~~SEC. 5.~~

~~SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

